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HOUSE BILL 2119 By
Bowers

SENATE BILL 2361
By Ford J

AN ACT to amend Tennessee Code Annotated, Title 56, to enact the "Provider-Sponsored Organization Act of 1998".

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF TENNESSEE:

SECTION 1. Tennessee Code Annotated, Title 56, is amended by adding Sections 2 through 21 of this act as a new, appropriately designated chapter to be cited as the "Provider-Sponsored Organization Act of 1998".

SECTION 2.

(a) The general assembly hereby finds, determines, and declares that the rapidly changing health care market provides unique opportunities for health care providers to organize themselves into new forms of collaborative systems to deliver high quality health care at competitive market prices to cooperatives and other purchasers. This act is enacted to encourage such collaborative arrangements and to further market-based competition among health care providers.

(b) The general assembly further recognizes that in order to achieve the most effective use of resources and medical technology to respond to changing market conditions, providers who would otherwise be competitors with each other will need to horizontally integrate in order to develop collaborative arrangements to guarantee an adequate number of providers to service the market and to vertically integrate in order to

guarantee that those who receive services will have a continuum of care as appropriate to their care needs.

(c) The general assembly also recognizes that to effect such new forms of collaborative systems and integration of providers to service the market will require an analysis of existing methods of providing services, contracting, collaborating, and networking among providers and the extent and type of regulatory oversight of licensed provider-sponsored networks or licensed individual providers which is appropriate to protect the public.

SECTION 3. As used in this act, unless the context otherwise requires:

(1) “Commissioner” means the commissioner of commerce and insurance.

(2) ”Limited service licensed provider-sponsored network health coverage plan” (LSLPN health coverage plan) means a contract, policy, certificate, or agreement entered into or issued by an LSLPN that agrees to assume the risk for specific, limited health care expenses and/or provide delivery of such services.

(3) “Limited service licensed provider-sponsored network” (LSLPN) means a provider-sponsored network that offers to contract directly with a consumer(s) (e.g., individual, group, employer, etc.) or their representative(s) to provide health care services restricted to:

(A) a narrowly defined health specialty (e.g., substance abuse, radiology, mental health, pediatrics, pharmacology, etc); or

(B) services narrowly limited to a single type of licensed health facility (e.g., inpatient hospital, birth center, long-term care facility, hospice, etc.); or

(C) home health care services delivered in the covered person’s residence only.

The services provided by the LSLPN must be limited in scope and must be significantly less than the basic health care services offered by a health maintenance organization or

under a comprehensive or major medical policy. An LSLPN must be licensed as an insurance company. Family practitioners, independent practice associations (IPAs) consisting of providers licensed in more than one specialty, or other similar medical/health collaborations do not meet the definition of a narrowly defined health specialty and therefore may not seek licensure under this limited license.

(4) "Provider-sponsored network" means a group of health care providers formed to provide health care services to individuals.

(5) "Risk assumption" or "risk sharing" means a transaction whereby the chance of loss, including the expenses for the delivery of service, with respect to the health care of a person is transferred to or shared with another entity (e.g., carrier, including an LSLPN), in return for a consideration. Examples include, but are not limited to, full or partial capitation agreements, withholds, risk corridors, and indemnity agreements. For the purposes of this act, fee-for-service, per diem payments, diagnostic-related group payment agreements, and employee assistance programs (EAPs) are not considered to be risk assumption or risk sharing arrangements.

SECTION 4.

(a) Health care providers are hereby authorized to conduct business collaboratively as provider-sponsored networks.

(b) (1) Except as provided in subdivision (2) (b), if a provider-sponsored network or individual provider proposes or is engaged in the transaction of insurance business or the activities of a health maintenance organization as defined in Title 56, Chapter 32, Part 2, such provider-sponsored network or individual provider must hold a certificate of authority from the commissioner to do business as an insurance company under Title 56, Chapter 2, Part 1 or to establish a health maintenance organization under Title 56, Chapter 32, Part 2.

(2) The fact that a provider-sponsored network or individual provider has a capitated contract or other agreement with a carrier, pursuant to which the provider-sponsored network or individual provider shares some of the risk of providing services to groups or individuals covered under a health care coverage plan issued by a carrier, shall not, in and of itself, be grounds for a determination by the commissioner that the provider-sponsored network or individual provider is engaged in the transaction of insurance business, so long as an officer of the provider-sponsored network or individual provider annually files a statement certifying that the network or provider is not engaged in the transaction of insurance business.

(3) A licensed provider-sponsored network or licensed individual provider shall be subject to applicable provisions of Title 48.

(c) A network organized on and after the effective date of this act, is organized when the articles of organization or articles of incorporation are filed by the secretary of state or, if a delayed effective date is specified in the articles as filed with the secretary of state and a certificate of withdrawal is not filed, on such delayed effective date. The existence of the network begins upon organization.

(d) If applicable, each provider-sponsored network shall file a report and pay the applicable fee required by law to the secretary of state.

(e) A provider-sponsored network or individual provider may request that specified information submitted to the department of commerce and insurance be kept confidential because it is a trade secret. The department shall honor such request unless the commissioner determines that the information is already public knowledge or that its confidentiality would be contrary to the public interest or the provider subsequently authorized the commissioner to release such information.

SECTION 5.

(a) Except as provided in subsection (b), the fact that an entity or provider is a member of a provider-sponsored network shall not exempt such entity or provider from any licensure or regulatory statute, nor shall any scope of practice of any provider be expanded, reduced, or otherwise modified by virtue of membership in or affiliation with any provider-sponsored network.

(b) Subject to any applicable federal requirement, including but not limited to 42 U.S.C. §1395nn, any provision of title 63 or 68 prohibiting the practice of any licensed or certificated health care profession as the partner, agent, or employee of or in joint venture with a person who does not hold a license or certificate to practice such profession within this state shall not apply to professional practice if a professional is participating in a provider-sponsored network organized pursuant to this act; and

(1) The partnership, agency, employment, or joint venture is evidenced by a written agreement containing language to the effect that the relationship created by the agreement may not affect the exercise of the licensed or certified professional's independent judgment in the practice of the profession;

(2) The licensed or certificated professional's independent judgment in the practice of such profession is in fact unaffected by the relationship; and

(3) The licensed professional is not required to exclusively refer any patient to a particular provider or supplier or take any other action the licensed professional determines not to be in the patient's best interest.

SECTION 6. Organization or operation as a provider-sponsored network is authorized under this act for the purpose of more cost-effective delivery of health care services, and shall not be construed as permitting any such collaborative system or any member of such provider-sponsored network to act in a concerted way to restrain trade or otherwise engage in practices which are otherwise prohibited by federal or state antitrust law.

SECTION 7. The provisions of this act apply to:

(1) Entities licensed as, or required to be licensed as, a sickness and accident insurance company, a non-profit hospital, medical-surgical, and health service corporation; or a health maintenance organization that contract with provider-sponsored networks for the delivery or provision of health care services;

(2) Entities required to be licensed as a limited service licensed provider-sponsored network (LSLPN); and

(3) A provider-sponsored network that only assumes risk from licensed carriers in accordance with the provisions of Section 20.

SECTION 8.

(a) A provider-sponsored network shall not issue any contract of insurance, including risk assumption or risk sharing agreements, nor shall it accept or assume all or part of the risk inherent in a contract issued by another entity, other than from a licensed carrier or with another entity that contracts with licensed carriers as allowed by this act, without first receiving a license from the commissioner.

(b) Provider-sponsored networks may apply to the department of commerce and insurance for a license to transact the business of insurance as follows:

(1) A provider-sponsored network may apply for licensure as a sickness and accident insurance company, medical-surgical, and health service corporation, or a health maintenance organization if the provider-sponsored network meets the applicable terms and conditions for such licensure. Once licensed, the provider-sponsored network shall be subject to all the statutory requirements of the insurance code under which it was licensed.

(2) A provider-sponsored network may apply for licensure as an LSLPN as provided by this act.

(A) In order to be eligible to make such application for this license, a provider-sponsored network must be legally bound and obligated to provide health care through an LSLPN.

(B) The provider-sponsored network must agree that in the event a member of the network is not able or willing to provide services to a consumer (e.g., individual, group, employer, etc.) under contract with the network, or any of its employees, the network will be obligated to continue providing such services.

(3) A provider-sponsored network that meets the definition of a health maintenance organization, or in the commissioner's opinion offers services which do not differ significantly from the basic services offered by an HMO, or that provides, either directly or through contractual or other arrangements with other hospitals and/or physicians, comprehensive or major medical services to enrollees shall not be eligible for licensure as an LSLPN.

(c) The commissioner may refuse to issue an LSLPN license for which a provider or provider-sponsored network has applied if, in the opinion of the commissioner, the applicant qualifies as a licensed carrier under another licensure category.

SECTION 9.

(a) A provider-sponsored network may apply for a license as an LSLPN on a form prescribed by the commissioner if it is eligible to make such application pursuant to the provisions of Section 8 of this act by filing one copy of the following:

(1) A written request for application to be licensed as a limited service licensed provider-sponsored network. Such request shall clearly disclose the type of authority being requested (e.g., a limited service license to provide home health care services, or inpatient hospital services, etc.), shall be accompanied

by a non-refundable filing fee of five hundred dollars ($500); and shall be signed by an officer or authorized representative of the applicant. If an applicant qualifies for licensure as an LSLPN, the applicant shall receive a certificate of authority limiting its right to insure only those health services requested on its application form. If the LSLPN discontinues providing any of these limited services, its certificate of authority shall be amended to include only those services that the LSLPN has the capacity, ability and legal authority to provide.

(2) A detailed summary of its proposed business plan with respect to its current business operations and its proposed plan as an LSLPN.

(3) A list of the providers comprising the LSLPN's provider-sponsored network.

(4) Information with regard to the measures and protections in place to ensure the financial solvency of the provider-sponsored network.

(5) A copy of the LSLPN's plan to coordinate benefits with respect to workers' compensation, personal injury protection benefits, third-party recovery and subrogation rights.

(6) Confirmation that the LSLPN uses standardized codes, billing processes and formats.

(7) Confirmation that the applicant has the capability to satisfactorily manage the health care coverage issued.

(8) Schedule of rates or charges, including all co-payments, deductibles, premiums and incidental fees. This information shall include the basis for calculation (e.g., use of usual, customary and reasonable UCR costs).

(9) Confirmation that the applicant has procedures to safeguard the privacy of any individually identifiable enrollee information; maintain records and

information in a manner that is accurate and timely; and assure timely access to enrollees.

(10) Confirmation that the applicant has a quality assurance program which meets the requirements of rules and regulations promulgated by the commissioner.

(11) Any other information deemed necessary by the commissioner in evaluating the application.

(b) Prior to implementing any material changes in its operations, or in the coverage offered by the LSLPN, and in no less than thirty (30) days prior to the anticipated change, the LSLPN shall submit to the commissioner a written description of any material modification to its plan of operations, or a written explanation of any material changes to the information submitted.

SECTION 10. All LSLPNs shall be responsible for meeting the following standards of operation both at the time of initial licensure, in the evaluation of their application, and continuously thereafter:

(1) Maintain an unqualified annual audited financial report certified by an independent certified public accountant (CPA), performed in accordance with generally accepted auditing standards (GAAS), based upon generally accepted accounting principles (GAAP). All CPA reports must provide separate detail for income and expenses derived from:

(1) Risk sharing and risk assumption arrangements between the LSLPN and licensed carriers; and

(2) The LSLPN Health Coverage Plans issued by the licensed LSLPN.

(b) Demonstrate financial stability to the commissioner and maintain a minimum net worth. Minimum net worth, excluding any goodwill or other intangible

assets, must be equal to such amount as may be determined by the commissioner and commensurate with the risk assumed by the LSLPN. Provided, however, such net worth shall not exceed the valuation included in the capital requirements established pursuant to § 56-32-212 for health maintenance organizations attributable to the type of care to be provided.

(c) Demonstrate its capacity to administer health plans being offered, and its ability to achieve, monitor, and evaluate the quality and cost-effectiveness of care being provided by its health care providers, and adequacy of its provider-sponsored network and third-party agreements in assuring reasonable access to care. This requirement shall be met by a certification by an independent reviewer and subject to acceptance by the commissioner.

(d) Provide for the collection of capitation fees/premium payments from the individual, employer, or group, on a monthly basis only, unless otherwise approved by the commissioner.

(e) Provide an annual certification by an executive officer of the LSLPN warranting the following:

All LSLPN health coverage plan(s), contracts or agreements or a combination thereof are not being offered and marked as substitute for comprehensive or major medical insurance coverage.

(f) Assure that all administrative and management agreements include a provision that the contract may not restrict the LSLPN governing body from appointing, removing or changing officers or employees of the LSLPN; a clear statement of the responsibilities and ownership of all books and records, assets, liabilities and compensation under the contract, where applicable; and if the LSLPN contracts for electronic data processing (EDP) and/or management information systems (MIS), a provision providing appropriate access to the system upon examination by the

commissioner, and a mechanism under which the system is available to the LSLPN or its successor upon insolvency of the LSLPN, or termination or cancellation of the contract.

(g) Provide a written notice of cancellation to the commissioner within sixty (60) days prior to canceling any administrative or management agreement.

SECTION 11. Each LSLPN shall deposit securities, acceptable to the commissioner, in an amount representing the minimum net worth required by Section 10, subsection (b).

SECTION 12. The funds received from enrollees must be treated in a fiduciary capacity. In order to protect the LSLPN contract holders from misuse of contractholder funds, an LSLPN shall maintain a fidelity bond covering the officers, directors, and employees who have access to the LSLPN funds. The fidelity bond must be issued by an insurance company holding a certificate of authority in this state.

SECTION 13. The license shall expire on June 30 of each year and shall be renewed annually if the LSLPN has continued to comply with this act. Every license shall automatically be extended until such time as the commissioner refuses to renew the license of such LSLPN.

SECTION 14.

(a) All LSLPN Health Coverage Plans, contracts, policies, and agreements shall be subject to all provisions of Title 56 that apply to health policies, plans, or contracts issued on a group basis, except as provided in rules and regulations promulgated by the commissioner.

(b) All LSLPN Health Coverage Plans shall contain a hold harmless provision acceptable to the commissioner, whereby the provider of health care services may only look to the LSLPN for compensation (except co-payments, co-insurance and deductibles) and shall not look to the covered person or restrict services as the result of nonpayment by the LSLPN.

(c) All LSLPN Health Coverage Plans shall prominently disclose on the front page of the plan the type of medical specialty benefits and/or limited health care service being provided, and shall state that the plan is being provided by an LSLPN. Such plan must clearly be labeled as a "Limited Service Licensed Provider-sponsored network Health Coverage Plan."

(d) All LSLPN Health Coverage Plans shall prominently disclose, in large type, in any written agreement, certificate, contract, plan, or policy issued by such LSLPN the following notice:

"NOTICE"

This health coverage plan is issued by your Limited Service Licensed Provider-sponsored network. This plan is subject to some but not to all of the insurance laws and regulations of Tennessee, and is not a substitute for comprehensive or major medical coverage. Tennessee insurance guaranty funds are not available for your Limited Service Licensed Provider-sponsored network Health Coverage Plan in the event of an insolvency of this plan."

SECTION 15.

(a) Every contractholder/enrollee shall be issued an evidence of coverage, which shall contain a clear and complete statement of:

(1) The limited health service to which each contractholder/enrollee is entitled;

(2) Any limitation of the service, kinds of service or benefits to be provided, and exclusions, including any deductible, co-payment or other charges;

(3) Where, and in what manner, information is available as to where and how services may be obtained; and

(4) The method for resolving complaints.

(b) Any amendment to the evidence of coverage shall be provided to the subscriber in a separate document at least thirty (30) days prior to the effective date of the amendment.

SECTION 16. A complaint system shall be maintained by all LSLPN in accordance with rules and regulations promulgated by the commissioner.

SECTION 17. The rates and charges shall be reasonable in relation to the service provided. No schedule of charges or rates shall be used by an LSLPN unless a copy of such schedule of charges or rates, or amendments thereto, has been filed with the commissioner prior to use. Rate filings are to include an actuarial certification that the rates are not excessive, inadequate or unfairly discriminatory. Rates and premiums for products issued by an LSLPN are to be determined on a fixed prepayment basis. Therefore, no LSLPN product may be issued on a cost plus or retrospective rating basis. An LSLPN may require co-payments, co-insurance or deductible payments of enrollees as a condition for the receipt of specific health service unless otherwise provided by law. Such payments for service shall be shown in the contract as a specified dollar amount or percentage. An annual certification, by a qualified actuary, to the appropriateness of the charges or rates, based on reasonable assumptions, shall accompany the annual rate filing along with adequate supporting information.

SECTION 18. It is the duty of all LSLPNs licensed pursuant to this act to comply with all other applicable state and federal regulations.

SECTION 19. An LSLPN's license may be suspended or revoked by the commissioner for failure to comply with the provisions of this act, or with any other applicable state regulations and statutes, or if the commissioner determines that continued licensure would be detrimental to the covered individuals, insurance buying public, or the general public of this state.

SECTION 20.

(a) A provider-sponsored network whose only risk assumption or risk sharing arrangements for the delivery of health care services are with licensed carriers who

retain full legal liability to the covered person for all benefits shall not be considered to be transacting the business of insurance if the provider-sponsored network certifies to the commissioner that it is not engaged in the business of insurance. The provider-sponsored network may be paid on a capitated basis and such capitated arrangement between licensed carrier(s) and provider-sponsored network(s) may include a provision that limits the services to be provided. If a provider-sponsored network modifies its business operations to issue any LSLPN Health Coverage Plan it shall be required to apply for a license as an LSLPN.

(b) If a provider or provider-sponsored network is unable to certify to the statements contained in the certification form, a detailed description and explanation must be immediately filed for review by the commissioner to determine if the provider-sponsored network is engaged in the unauthorized transaction of the business of insurance.

SECTION 21. The commissioner is authorized to promulgate rules and regulations to effectuate the purposes of this act. All such rules and regulations shall be promulgated in accordance with the provisions of Tennessee Code Annotated, Title 4, Chapter 5.

SECTION 22. If any provision of this act or the application thereof to any person or circumstance is held invalid, such invalidity shall not affect other provisions or applications of the act which can be given effect without the invalid provision or application, and to that end the provisions of this act are declared to be severable.

SECTION 23. For purposes of promulgating rules and regulations, this act shall take effect upon becoming a law, the public welfare requiring it. For all other purposes this act shall take effect July 1, 1998, the public welfare requiring it.